Alberta

Client Consent

Protected A (when completed)

Alberta Aids to Daily Living (AADL)

This form is used to obtain consent from the client to allow Alberta Health, Alberta Blue Cross, and Alberta Health Services to disclose the client's personal/health information to AADL vendors/specialty suppliers or authorizers. The information on this form is being collected and used pursuant to sections 20, 21, 22 and 27 of the *Health Information Act*, sections 33(a) & (c) and 34 of the *Freedom of Information and Protection of Privacy Act (FOIP)* and the Alberta Aids to Daily Living and Extended Health Benefits Regulations. If you have questions about the collection of your information, you can contact the Alberta Aids to Daily Living program at ATB Place North, 10025 Jasper Ave NW, Edmonton, AB T5J 1S6; Telephone: 780-427-0731, Fax:780-422-0968.

Please return completed forms to your assessor or authorizer. Do not fax forms to AADL.

Collection of Personal Information

I, ______________________________
Name

(the client), authorize my individually identifying personal and health information related to my eligibility for Alberta Aids to Daily Living (AADL) benefits to be disclosed by Alberta Health, Alberta Blue Cross and Alberta Health Services, in accordance with section 40(1)(d) of the *Freedom of Information and Protection of Privacy Act*, section 7(2) of the FOIP regulations, and section 34 of *the Health Information Act,* to approved AADL vendors/specialty suppliers or authorizers for the provision of and billing for AADL benefits.

I understand why I have been asked to disclose my individually identifying information and am aware of the risks or benefits of consenting, or refusing to consent, to the disclosure of my individually identifying information.

I understand that I may revoke this consent in writing at any time by contacting the Alberta Aids to Daily Living program using the contact information at the top of this form.

Date yyyy-mm-dd	Signature

If the client is unable to sign, an individual who may legally exercise the rights of the client under section 104(1) of the *Health Information Act* may sign this consent form for the client. The individual signing for the client must print their name, phone number and relationship to the client.

Name of individual signing for client (if applicable)	Phone Number

Relationship to client

For the individual collecting this consent form: I confirm that I have explained this consent form to the client, or the individual signing for the client, as named above. I confirm that I verified the identification provided by the client, or the individual signing for the client, as named above.
Name of individual collecting consent